DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: DME Providers
Pharmacists
Infusion Therapy Providers
Managed Care Plans
Regional Administrators
CSO Administrators

Memorandum No: 03-68 MAA
Issued: September 18, 2003

For Information Call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Subject: Medical Nutrition Program: HIPAA Changes

Effective for dates of service on and after October 1, 2003, providers must use the updated replacement pages to MAA's Medical Nutrition Billing Instructions, dated November 2000, attached to this memorandum when billing the Medical Assistance Administration (MAA) for medical nutrition supplies and services provided to clients.

Modifiers

Effective for dates of service on and after October 1, 2003, the only appropriate modifier to use for oral medical nutrition is the BO modifier. For specifics on using the BO modifier refer to attached replacement page E.1/E.2 which replaces pages E.1-E.10 of MAA's Medical Nutrition Billing Instructions, dated November 2000.

Coding Changes

The Health Insurance Portability and Accountability Act (HIPAA) requires all healthcare payers to process and pay claims using a standardized set of procedure codes. MAA is discontinuing all state-unique procedure codes and modifiers and will require the use of applicable HCPCS* procedure codes.

MAA has updated the product list and fee schedule in MAA's Medical Nutrition Billing Instructions, dated November 2000, to reflect HIPAA implementation. Attached are replacement pages F.1 - F.8, which replace pages F.1 - F.10 and pages H.1 - H.6, which replace pages H.1 - H.8 of MAA's Medical Nutrition Billing Instructions, dated November 2000.

*** HCPCS stands for Healthcare Common Procedure Coding System**

Prior Authorization

MAA has updated this section to reflect the new Expedited Prior Authorization (EPA) requirements for the Medical Nutrition program. Attached are replacement pages G.1 - G.6 for MAA's Medical Nutrition Billing Instructions, dated November 2000.

Claim Form Instructions

With HIPAA implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing using a **paper HCFA-1500 claim form** for supplies or equipment using **multiple** EPA numbers, you must list the 9-digit EPA numbers in **field 19** of the claim form **exactly** as follows (*not all required fields are represented in the example*):

19. Line 1: 870000725/ Line 2: 870000726

If you are only billing one EPA number on a paper HCFA-1500 claim form, please continue to list the 9-digit EPA number in field 23 of the claim form.

Attached are replacement pages J.3 - J.6 and J.11 - J.14 for MAA's Medical Nutrition Billing Instructions, dated November 2000.

Product Classification

According to the Centers for Medicare/Medicaid Services (CMS) guidelines, all enteral nutrition formulas are classified under one of six categories based on the composition and source of the ingredients in each product. Attached to this memorandum is a complete list of the categories and the formulas under each category to be used as an Appendix to MAA's Medical Nutrition Billing Instructions, dated November 2000.

To obtain this document electronically, go to MAA's website at http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

*** HCPCS stands for Healthcare Common Procedure Coding System**

Modifiers

Effective with dates of service on and after October 1, 2003, providers must use the procedure codes listed in the product list along with a modifier, if applicable, for all medical nutritionals.

Modifier 'BO'

What does the modifier signify?

Modifier 'BO' is to be used for medically necessary, orally administered nutrition, not nutrition administered by external tube. This is the only modifier accepted by MAA for medical nutritionals.

All oral nutritionals must have documented justification for medical necessity in the client's file and made available for review by MAA. Claims for reimbursement of oral nutritionals must be billed with the ICD-9-CM diagnosis code that indicates a functional impairment of an organ or process.

Note…

Medicare Part B only covers nutritional products for clients who are tube-fed. Nutritional products being appropriately billed with a 'BO' modifier will not require a Medicare denial and can be billed directly to MAA.

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Product List

Effective with dates of service on and after October 01, 2003, providers must use the applicable HCPCS codes for all medical nutritional claims. **Please note: a modifier of BO must be used when the product is being administered orally.**

Product Name	Discontinued Code	New HCPCS Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Unit must be rounded to the nearest whole number.				
Advera	0000B	B4154	100 cal	$1.60
Additions	0412B	B4155	100 cal	$0.89
Alimentum	0001B	B4153	100 cal	$2.97
AlitraQ	0002B	B4154	100 cal	$1.60
Amino-Aid	0003B	B4154	100 cal	$1.60
Beneprotein (see Resource Beneprotein)				
Boost (with or without fiber)	0004B	B4150	100 cal	$0.92
Boost Breeze **(PA Required)**	0400B	B9998		
Boost HP	0005B	B4150	100 cal	$0.92
Boost Plus	0006B	B4152	100 cal	$0.62
Calcilco XD Pwd	0388B	B4154	100 cal	$1.60
Carnation Alsoy	0008B	B4150	100 cal	$0.92
Carnation Follow-up	0009B	B4150	100 cal	$0.92
Carnation Good Start	0010B	B4150	100 cal	$0.92
Casec	0011B	B4155	100 cal	$0.89
Choice DM	0012B	B4154	100 cal	$1.60
Choice DM Bar **(PA Required)**	0013B	B9998		
Compleat Modified	0014B	B4151	100 cal	$0.94
Compleat Pediatric	0015B	B4151	100 cal	$0.94
Comply	0016B	B4152	100 cal	$0.62
Criticare HN	0017B	B4153	100 cal	$2.97
Crucial	0019B	B4153	100 cal	$2.97
Cyclinex 1	0021B	B4153	100 cal	$2.97
Cyclinex 2	0023B	B4153	100 cal	$2.97
Deliver 2.0	0025B	B4152	100 cal	$0.62
Diabetisource	0027B	B4154	100 cal	$1.60

Product Name	Discontinued Code	New HCPCS Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Unit must be rounded to the nearest whole number.				
Diabetisource AC	0411B	B4154	100 cal	$1.60
Duocal	0414B	B4155	100 cal	$0.89
Elecare	0028B	B4153	100 cal	$2.97
Enfacare	0029B	B4150	100 cal	$0.92
Enfamil	0365B	B4150	100 cal	$0.92
Enfamil 22	0030B	B4150	100 cal	$0.92
Enfamil AR	0031B	B4150	100 cal	$0.92
Enfamil LactoFree	0032B	B4150	100 cal	$0.92
Enfamil Next Step	0033B	B4150	100 cal	$0.92
Enlive **(PA Required)**	0034B	B9998		
Ensure (with or without fiber)	0039B	B4150	100 cal	$0.92
Ensure Bar **(PA Required)**	0035B	B9998		
Ensure High Protein	0036B	B4150	100 cal	$0.92
Ensure Plus	0037B	B4152	100 cal	$0.62
Ensure Plus HN	0038B	B4152	100 cal	$0.62
FAA (Free Amino Acid Diet)	0397B	B4153	100 cal	$2.97
FiberSource	0040B	B4150	100 cal	$0.92
FiberSource HN	0041B	B4150	100 cal	$0.92
GA 1 and 2	0042B	B4153	100 cal	$2.97
Generic/Store Brand Formula ***Note:*** *Providers may bill for Generic or Store Brand products only when the content of the product is the same as Ensure, Boost, or NuBasics.*	0399B	B4150	100 cal	$0.92
Glucerna	0043B	B4154	100 cal	$1.60
Glucerna Bar **(PA Required)**	0044B	B9998		
Glucerna Shake	0045B	B4154	100 cal	$1.60
Glutarex 1	0046B	B4153	100 cal	$2.97
Glutarex 2	0047B	B4153	100 cal	$2.97
Glutasorb	0385B	B4153	100 cal	$2.97
Glytrol	0048B	B4150	100 cal	$0.92
HCY 1 and 2	0049B	B4154	100 cal	$1.60

Product Name	Discontinued Code	New HCPCS Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Unit must be rounded to the nearest whole number.				
Hepatic-Aid	0050B	B4154	100 cal	$1.60
Hominex 1	0051B	B4153	100 cal	$2.97
Hominex 2	0052B	B4153	100 cal	$2.97
Immun-Aid	0053B	B4154	100 cal	$1.60
Immunocal	0389B	B4155	100 cal	$0.89
Impact 1.5	0054B	B4154	100 cal	$1.60
Impact (with or without fiber)	0055B	B4154	100 cal	$1.60
Impact Glutamine	0417B	B4153	100 cal	$2.97
Impact Recover	0415B	B4154	100 cal	$1.60
Isocal	0056B	B4150	100 cal	$0.92
Isocal HN	0057B	B4150	100 cal	$0.92
Isocal HN Plus	0390B	B4150	100 cal	$0.92
Isomil	0059B	B4150	100 cal	$0.92
Isomil DF	0061B	B4150	100 cal	$0.92
Isosource 1.5	0064B	B4152	100 cal	$0.62
Isosource	0063B	B4150	100 cal	$0.92
Isosource HN	0065B	B4150	100 cal	$0.92
Isosource VHN	0066B	B4154	100 cal	$1.60
Isotein HN	0067B	B4153	100 cal	$2.97
Jevity	0068B	B4150	100 cal	$0.92
Jevity Plus	0069B	B4150	100 cal	$0.92
KetoCal	0410B	B4151	100 cal	$0.94
Ketonex 1	0071B	B4153	100 cal	$2.97
Ketonex 2	0073B	B4153	100 cal	$2.97
Kindercal	0075B	B4150	100 cal	$0.92
Kindercal TF w/Fiber	0391B	B4150	100 cal	$0.92
Lipisorb Liquid	0077B	B4154	100 cal	$1.60
L-Emental	0380B	B4153	100 cal	$2.97
L-Emental Hepatic	0381B	B4154	100 cal	$1.60
Lofenalac	0079B	B4154	100 cal	$1.60
LYS 1 and 2	0081B	B4154	100 cal	$1.60
Magnacal Renal	0083B	B4154	100 cal	$1.60
MCT Oil	0085B	B4155	100 cal	$0.89

Product Name	Discontinued Code	New HCPCS Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Unit must be rounded to the nearest whole number.				
Microlipids	0087B	B4155	100 cal	$0.89
Modulen IBD	0395B	B4154	100 cal	$1.60
MSUD	0089B	B4154	100 cal	$1.60
MSUD 2	0091B	B4154	100 cal	$1.60
Neocate	0093B	B4153	100 cal	$2.97
Neocate One Plus	0095B	B4153	100 cal	$2.97
NeoSure	0097B	B4150	100 cal	$0.92
Nepro	0100B	B4154	100 cal	$1.60
Novasource 2.0	0406B	B4152	100 cal	$0.62
Novasource Renal	0101B	B4154	100 cal	$1.60
Novasource Pulmonary	0102B	B4152	100 cal	$0.62
NuBasics (with or without fiber)	0108B	B4150	100 cal	$0.92
NuBasics 2.0	0103B	B4152	100 cal	$0.62
NuBasics Bar **(PA Required)**	0104B	B9998		
NuBasics Fruit Beverage **(PA Required)**	0105B	B9998		
NuBasics Plus	0106B	B4152	100 cal	$0.62
NuBasics VHP	0107B	B4150	100 cal	$0.92
Nutramigen	0109B	B4150	100 cal	$0.92
Nutren 1.0 (with or without fiber)	0110B	B4150	100 cal	$0.92
Nutren 1.5	0111B	B4152	100 cal	$0.62
Nutren 2.0	0113B	B4152	100 cal	$0.62
Nutren Junior (with or without) fiber	0114B	B4150	100 cal	$0.92
Nutrihep	0115B	B4154	100 cal	$1.60
Nutrirenal	0370B	B4154	100 cal	$1.60
Nutrivent	0116B	B4154	100 cal	$1.60
Optimental	0392B	B4153	100 cal	$2.97
OS 1 and 2	0117B	B4154	100 cal	$1.60
Osmolite	0118B	B4150	100 cal	$0.92
Osmolite HN	0119B	B4150	100 cal	$0.92
Osmolite HN Plus	0120B	B4150	100 cal	$0.92
Pediasure (with or without fiber)	0121B	B4150	100 cal	$0.92
Ped Peptinex DT (with or without fiber)	None	B4153	100 cal	$2.97

Product Name	Discontinued Code	New HCPCS Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Unit must be rounded to the nearest whole number.				
Peptamen	0122B	B4154	100 cal	$1.60
Peptamen 1.5	0123B	B4153	100 cal	$2.97
Peptamen with Prebio 1	0396B	B4153	100 cal	$2.97
Peptamen Junior	0124B	B4154	100 cal	$1.60
Peptamen VHP	0125B	B4154	100 cal	$1.60
Peptinex DT	0409B	B4153	100 cal	$2.97
Perative	0126B	B4154	100 cal	$1.60
PFD2	0127B	B4155	100 cal	$0.89
Phenex 1	0128B	B4153	100 cal	$2.97
Phenex 2	0129B	B4153	100 cal	$2.97
PhenylAde	0130B	B4155	100 cal	$0.89
PhenylAde MTE	0131B	B4155	100 cal	$0.89
Phenyl-Free	0132B	B4154	100 cal	$1.60
Phenyl-Free 2	0133B	B4154	100 cal	$1.60
Phenyl-Free HP2	0134B	B4154	100 cal	$1.60
Polycose Liquid	0135B	B4155	100 cal	$0.89
Polycose Powder	0136B	B4155	100 cal	$0.89
Portagen	0137B	B4150	100 cal	$0.92
Pregestimil	0138B	B4154	100 cal	$1.60
Probalance	0139B	B4150	100 cal	$0.92
Pro-Cel	0401B	B4155	100 cal	$0.89
Product 3200AB	0140B	B4154	100 cal	$1.60
Product 3232	0141B	B4154	100 cal	$1.60
Product 80056	0142B	B4155	100 cal	$0.89
Promod	0143B	B4155	100 cal	$0.89
Promote (with or without fiber)	0145B	B4150	100 cal	$0.92
Pro-Peptide	0382B	B4154	100 cal	$1.60
Pro-Peptide VHN	0383B	B4154	100 cal	$1.60
Pro-Peptide for Kids	0384B	B4154	100 cal	$1.60
ProPhree	0147B	B4155	100 cal	$0.89
Propimex 1	0149B	B4153	100 cal	$2.97
Propimex 2	0159B	B4153	100 cal	$2.97
ProSobee	0160B	B4151	100 cal	$0.94

Product Name	Discontinued Code	New HCPCS Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Unit must be rounded to the nearest whole number.				
ProSure	0413B	B4155	100 cal	$0.89
Protein Eight Bar **(PA Required)**	0387B	B9998		
ProViMin	0164B	B4155	100 cal	$0.89
Pulmocare	0167B	B4154	100 cal	$1.60
RCF	0168B	B4155	100 cal	$0.89
Re/Neph	0393B	B4154	100 cal	$1.60
Reabilan	0169B	B4153	100 cal	$2.97
Reabilan HN	0170B	B4153	100 cal	$2.97
Regain Bar **(PA Required)**	0177B	B9998		
Renal Cal	0178B	B4154	100 cal	$1.60
Replete (with or without fiber)	0179B	B4154	100 cal	$1.60
Resource	0180B	B4150	100 cal	$0.92
Resource Arginaid	0403B	B4155	100 cal	$0.89
Resource Bar **(PA Required)**	0181B	B9998		
Resource Benecalorie	0419B	B4154	100 cal	$1.60
Resource Beneprotein	0405B	B4155	100 cal	$0.89
Resource Diabetic	0182B	B4150	100 cal	$0.92
Resource Diabetishield	0416B	B4154	100 cal	$1.60
Resource Fruit Beverage **(PA Required)**	0183B	B9998		
Resource GlutaSolve	0407B	B4155	100 cal	$0.89
Resource Just for Kids	0184B	B4150	100 cal	$0.92
Resource Plus	0188B	B4152	100 cal	$0.62
Resource ThickenUp	0404B	B4100	1 pwd oz	$0.18
Respalor	0189B	B4152	100 cal	$0.62
SandoSource Peptide	0190B	B4154	100 cal	$1.60
Similac	0194B	B4150	100 cal	$0.92
Similac PM 60/40	0195B	B4154	100 cal	$1.60
Subdue	0197B	B4153	100 cal	$2.97
Suplena	0198B	B4154	100 cal	$1.60
Thick & Easy	0199B	B4100	1 pwd oz	$0.16
Thick-It	0200B	B4100	1 pwd oz	$0.16
Tolerex	0203B	B4156	100 cal	$3.55

Product Name	Discontinued Code	New HCPCS Code	Unit	Maximum Allowable
Billing must be limited to a 1-month supply. Unit must be rounded to the nearest whole number.				
TraumaCal	0204B	B4154	100 cal	$1.60
TwoCal HN	0386B	B4152	100 cal	$0.62
Tyrex 2	0205B	B4153	100 cal	$2.97
Tyros 2	0209B	B4154	100 cal	$1.60
UCD 1 and 2	0210B	B4154	100 cal	$1.60
Ultracal	0371B	B4150	100 cal	$0.92
Ultracal HN Plus	0394B	B4150	100 cal	$0.92
Upcal D	0402B	B4155	100 cal	$0.89
Valex 1	0217B	B4153	100 cal	$2.97
Valex 2	0218B	B4153	100 cal	$2.97
VHC 2.25	0418B	B4152	100 cal	$0.62
Vital HN	0219B	B4153	100 cal	$2.97
Vivonex Pediatric	0376B	B4153	100 cal	$2.97
Vivonex Plus	0377B	B4154	100 cal	$1.60
Vivonex TEN	0220B	B4154	100 cal	$1.60

Fiber/Hydration Products

Fiber and hydration products are covered on a limited basis through MAA's Prescription Drug Program.

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Prior Authorization

What is prior authorization?

Prior authorization is MAA approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization and limitation extensions are forms of prior authorization.**

Is prior authorization required for medical nutrition?

Yes! MAA requires providers to obtain prior authorization for the following:

- All medical nutritional bars and beverages;
- Procedure code B9998 for miscellaneous medical nutrition;
- Procedure code B9998 for Low Profile Gastronomy Replacement Kit requires EPA #870000742 to be entered in field 19 on the HCFA-1500 claim form; and
- Procedure code E1399 for repair parts for client-owned equipment requires EPA #870000743 to be entered in field 19 on the HCFA-1500 claim form with an invoice attached.

What is expedited prior authorization?

The expedited prior authorization (EPA) process is designed to eliminate the need for written and telephonic requests for prior authorization for selected procedure codes. MAA allows payment during a continuous 12-month period for this process.

To bill MAA for medical nutritionals that meet the EPA criteria on the following pages, the vendor must create a 9-digit EPA number. The first 6 digits of the EPA number must be **870000.** The last 3 digits document the product description and conditions that make up the EPA criteria. Enter the EPA number on the HCFA-1500 claim form in the **field 19** or in the ***Authorization*** or ***Comments*** field when billing electronically. With HIPAA implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing **multiple** EPA numbers, you must list the 9-digit EPA numbers in field 19 of the claim form **exactly** as follows (*not all required fields are represented in the example*):

19. Line 1: 870000725/ Line 2: 870000726

If you are only billing one EPA number on a paper HCFA-1500 claim form, please continue to list the 9-digit EPA number in field 23 of the claim form.

Example: The 9-digit EPA number for Low Profile Gastrostomy Replacement Kit for a client that meets all of the EPA criteria would be **870000742** (870000 = first 6 digits, 742 = product and documented medical condition).

Vendors are reminded that EPA numbers are only for those products listed in the fee schedule as requiring EPA numbers. EPA numbers are not valid for:

- Other medical nutritionals requiring prior authorization through the Medical Nutrition program;
- Products for which the documented medical condition does not meet all of the specified criteria; or
- Over-limitation requests.

The written/fax request for prior authorization process must be used when a situation does not meet the criteria for a selected procedure code. Providers must submit the request in writing and fax it to MAA at:

Division of Medical Management
Program Management and Authorization Section
Attn: Medical Nutrition Program Manager
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-1471

Expedited Prior Authorization Guidelines:

A. **Medical Justification (criteria)** - All medical justification must come from the client's prescribing physician with an appropriately completed prescription. MAA does not accept information obtained from the client or from someone on behalf of the client (e.g. family).

B. **Documentation** - The billing provider **must keep** documentation of the criteria in the client's file. Upon request, a provider must provide documentation to MAA showing how the client's condition met the criteria for EPA. Keep documentation on file for six (6) years. [Refer to WAC 388-502-0020]

☞ **Note:** MAA may recoup any payment made to a provider under this section if the provider did not follow the expedited authorization process and criteria. Refer to WAC 388-502-0100.

What is a limitation extension?

A limitation extension is when MAA allows additional units of service for a client when the provider can verify that the additional units of service are medically necessary. Limitation extensions require authorization.

☞ **Note:** Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

When should I request a limitation extension for medical nutrition?

Under the Medical Nutrition Program, a limitation extension must be requested when it is medically necessary to provide more units of supplies than allowed in MAA's billing instructions.

How do I request a limitation extension?

In cases where the provider feels that additional services are still medically necessary for the client, the provider must request MAA-approval in writing.

The written requests must state the following:

1. The name and PIC number of the client;
2. The provider's name, provider number and fax number;
3. Additional service(s) requested;
4. Copy of last prescription and date dispensed;
5. Copy of the oral enteral nutrition form;
6. The primary diagnosis code and HCPCS code; and
7. Client-specific clinical justification for additional services.

For medical nutritionals, submit the above information to MAA (see Important Contacts). A sample Medical Nutrition Limitation Extension Request form is on page G.5 for your convenience.

For additional units of supplies, send or fax medical justification to MAA.

Where do I send my limitation extension request?

Send or fax your request and medical justification to:

Division of Medical Management
Medical Programs Management Unit- Limitation Extension
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-1471

☞ **Note:** All limitation extensions are subject to the client's eligibility. Not all eligibility groups receive all services. See *Client Eligibility Section*.

Medical Nutritionals Limitation Extension Request

Name, Company, Title of Requestor			
Phone Number		Fax Number	
Provider number		Patient PIC number	
Name Phone Number of Nutritionist			

Nutritional evaluation included ☐ yes ☐ No Tube Fed ☐ Yes ☐ No

Weight for this client ____ Kgs

Caloric Requirement (for this client) ____

Normal Calories per day required for someone of this age ____ Breast Fed ☐ Yes ☐ No

Diagnosis or Reason for requested formula

WIC denial enclosed or amount received from WIC ____

Type of Formula ____

Amount Required ____

Concentration used (i.e. 8oz can/1lb powder) ____

Medical Assistance Use Only

Total Cal mo		WIC Cal mo	
Remainder		Date span	
Auth Number		Procedure Code	
Units or Dollar amount			

Special Instructions ____

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Fee Schedule

Equipment Rental/Purchase Policy

- The following are included in MAA's reimbursement for equipment rentals or purchases:

  ✓ Instructions to the client and/or caregiver on the safe and proper use of equipment provided;
  ✓ Full service warranty;
  ✓ Delivery and pick-up; and
  ✓ Fitting and adjustments.

- If death, ineligibility, or other change in circumstances occur during the rental period, MAA will terminate reimbursement at that time.

- Providers may not bill for a rental and a purchase of any item simultaneously.

- MAA will not reimburse providers for equipment that was supplied to them **at no cost** through suppliers/manufacturers.

- All rent-to-purchase equipment must be new at the beginning of the rental period.

- MAA reimburses for medical nutrition related supplies for client's residing in nursing facilities **only:**

  ✓ When they are used to administer 100% of the client's nutritional requirements; and
  ✓ When the client's medical circumstances meet MAA's requirements for medical nutrition.

  ☞ **Note:** Covered items that are not part of the nursing home per diem may be billed separately to MAA.

- MAA reimburses for medical nutrition related supplies for client's receiving Medicare Part B **only:**

  ✓ When they are used to administer medical nutritionals to non tube-fed clients; and
  ✓ When the client's medical circumstances meet MAA's requirements for medical nutrition.

Enteral Supply Kits

- **Do not bill more than one supply kit code per day.**
- **Enteral supply kits include all the necessary supplies for the enteral patient using the syringe, gravity or pump method of nutrient administration.**
- **Bill only for the actual number of kits used, not to exceed a one-month supply.**

Procedure Code	Description	Maximum Allowable Fee	Rental	Purchase	Maximum Number of Units	Part of NH per diem
B4034	Enteral Feeding Supply Kit; Syringe (Bolus only)	$5.60	N	Y	1 per client, per day	N
B4035	Enteral Feeding Supply Kit; Pump Fed, per day.	$10.67	N	Y	1 per client, per day	N
B4036	Enteral Feeding Supply Kit; Gravity Fed	$7.31	N	Y	1 per client, per day	N

Enteral Tubing

- **You may bill only one type of enteral tube per client, per day.**
- **The total number of allowed tubes includes any tubes provided as part of the replacement kit.**

Procedure Code	Description	Maximum Allowable Fee	Rental	Purchase	Maximum Number of Units	Part of NH per diem
B4081	Nasogastric tubing with stylet (each)	$19.78	N	Y	3 per client, per month	N
B4082	Nasogastric tubing without stylet (each)	$14.73	N	Y	3 per client, per month	N
B4083	Stomach tube – Levine type (each)	$2.25	N	Y	1 per client, per month	N
B9998	Low Profile Gastrostomy Replacement Kit (e.g., Bard, MIC Key Button, Hide-a-port, Stomate). **EPA #: 870000742**	$106.87	N	Y	2 per client, every 5 months	N
B4086	Gastrostomy/jejunostomy tube, any material, any type (standard or low profile), (each)	$32.66	N	Y	5 per client, per month	N

Enteral Repairs

Procedure Codes	Description	Maximum Allowable Fee	Rental	Purchase	Maximum Number of Units	Part of NH per diem
E1399	Repair Parts for Enteral Equipment. Only those client-owned pumps less than five (5) years old, and no longer on warranty will be allowed replacement parts. **EPA #: 870000743 (Invoice required.)**	85%	N/A	N/A		N
E1340	Repair or nonroutine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes.	$17.43	N/A	N/A		N

Pumps and Poles

- **May bill for only one type of enteral pump code per month.**
- **Enteral poles are considered purchased after 12 months' rental.**
- **Enteral pumps are considered purchased after 15 months' rental.**
- **Pumps must be new equipment at beginning of rental period.**

Procedure Code	Description	Maximum Allowable Fee	Rental	Purchase	Maximum Number of Units	Part of NH per diem
E0776-NU	IV pole. Purchase. Modifier required.	$93.30	N	Y	1 per client, per lifetime	Y
E0776-RR	IV pole. Rental. Modifier required.	$9.33	Per month	N	1 per month; not to exceed 12 months	Y
B9998	Included in pump purchase. **EPA #: 870000744.**	$100.58	N	Y	1 every 5 years	N
B9002-RR	Enteral nutrition infusion pump with alarm.	$108.66	Per month	N	1 per month; not to exceed 15 months	N

Miscellaneous						
• **MAA review is required prior to billing this code.**						
Procedure Code	**Description**	**Maximum Allowable Fee**	**Rental**	**Purchase**	**Maximum Number of Units**	**NH per diem**
B9998	NOC for enteral supplies (other medical nutrition supplies not listed).	To be determined by MAA				

Miscellaneous Procedure Code

In order to be reimbursed for miscellaneous medical nutrition procedure code B9998, all the information in the attached form must be submitted to MAA prior to submitting your claim to MAA. A sample form is attached for your convenience (see page H.5).

Do not submit claims using procedure code B9998 until you have received an authorization number from MAA indicating that your bill has been reviewed.

Include the following supporting documentation with your fax:

- Agency name and provider number;
- Client PIC;
- Date of service;
- Name of piece of equipment;
- Invoice;
- Prescription;
- Explanation of client-specific, medical necessity; and
- Name of primary piece of equipment and whether the equipment is rented or owned.

You may make copies of the attached form and mail/fax it to:

Medical Assistance Administration
Medical Nutrition Program
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471

Justification for use of B9998 Miscellaneous Medical Nutrition Procedure Code
★Fax this form to obtain authorization prior to submitting your claim
Attn: Medical Nutrition Program **Fax: 360 586-1471** ***Also fax: Your Invoice Prescription***

Agency Name: _____ Agency Provider #: _____
Client Name: _____ Client PIC: _____
Client Diagnosis: _____

Date of Service: _____ Name of the Equipment: _____
Medical Necessity: _____
Units Requested _____

Date of Service: _____ Name of the Equipment: _____
Medical Necessity: _____
Units Requested _____

Date of Service: _____ Name of the Equipment: _____
Medical Necessity: _____
Units Requested _____

Date of Service: _____ Name of the Equipment: _____
Medical Necessity: _____
Units Requested _____

For MAA USE ONLY		
Decision: ☐ Approved ☐ Denied Not Medically Necessary ☐ Alternate Code suggested _____,		
Description _____, Payment per Unit _____ , Total Payment _____		
Logged Date:		Need to establish code: ☐ Yes ☐ No

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: For clients 17 years of age and younger, enter the certified dietitian's name.

17a. **ID Number of Referring Physician**: For clients 17 years of age and younger, enter the MAA 7-digit certified dietitian provider number.

19. **Reserved for Local Use**: When applicable, enter one of the following indicators:

"**B" -** *Baby on Parent's PIC. (*Please specify twin A or B, triplet A, B, or C here)
"F" – Clients 4 years of age and younger when WIC is not being used.
"K" – Clients who have elected the hospice benefit, when billed charges are unrelated to the terminal diagnosis.
"L" – When the transition time from parenteral nutrition to medical nutritionals is greater than 3 months.
"**100 % nutrition - not included in NH**" **-** When billing for medical nutritionals for nursing home clients.

"**Not tube fed - Medicare does not cover.**"- When client has Medicare Part B.

If you have more than one EPA number to bill, place both numbers here.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

23. **Prior Authorization Number**: When applicable. If the service or equipment you are billing requires authorization, enter the 9-digit number assigned to you. Only one authorization number is allowed per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 8, 2003 = 100803). ***Bill must not exceed a 1-month supply.***

24B. **Place of Service**: Required. Enter the following code:

Code	To Be Used For
12	Client's residence
22	Outpatient hospital
31	Nursing facility (formerly SNF)
32	Nursing facility (formerly ICF)

24C. **Type of Service**: Not Required.

24D. **Procedures, Services or Supplies HCPCS**: Required. Enter the appropriate HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed.

Modifier: Must use the appropriate modifier when billing for medical nutritionals and supplies.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code that evidences the need for the use of medical nutritionals. A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units (not to exceed a 1-month supply) for each line. These figures must be whole units.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**: Required. Put the *Name, Address,* and *Telephone Number* on all claim forms.

GRP#: **Required.** Enter the 7-digit provider number assigned by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

WITH PRIOR AUTHORIZATION

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PT 032796 SMITH A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, PAT

3. PATIENT'S BIRTH DATE MM DD YY: 03 27 96 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): PO BOX 17

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR. JONES

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 8888888

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250.
2. .
3. .
4. .

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 354912345

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	10	01	03	10	01	03	12		B4034		250	1000	1				
2	10	01	03	10	30	00	12		B9998		250	27500	30				
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 28500

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 28500

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

UPTOWN MEDICAL SUPPLY
13 ROSE STREET
UPTOWN, WA 98000 (206) 555-1111

PIN# 9045681 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

WITH EXPEDITED PRIOR AUTHORIZATION

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PT 032796 SMITH A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, PAT

3. PATIENT'S BIRTH DATE MM DD YY: 03 27 96 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): PO BOX 17

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR. JONES

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 8888888

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: LINE 1: 870000742/ LINE 2: 870000743

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250.__ 3. _____.__

2. _____.__ 4. _____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 354912345

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 01 03	10 01 03	12		B9998		250	15000	1				
2 10 01 03	10 30 00	12		B4150		250	27500	30				
3 10 01 03	10 01 03	12		E1399		250	10000	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 52500

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 52500

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

UPTOWN MEDICAL SUPPLY
13 ROSE STREET
UPTOWN, WA 98000 (206) 555-1111

PIN# 9045681 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*.

17. **Name of Referring Physician or Other Source**: For clients 17 years of age and younger, enter the certified dietitian's name.

17a. **ID Number of Referring Physician**: For clients 17 years of age and younger, enter the MAA 7-digit certified dietitian provider number.

19. **Reserved For Local Use: Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission:** When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.**

24A. **Date(s) of Service:** Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day or year (MMDDYY).**

24B. **Place of Service:** Required. Enter the following code:

Code	To Be Used For
12	Client's residence
22	Outpatient hospital
31	Nursing facility (formerly SNF)
32	Nursing facility (formerly ICF)

24C. **Type of Service:** Not Required.

24D. **Procedures, Services or Supplies HCPCS: Required. Coinsurance and Deductible:** Enter the total combined and deductible for each service in the space to the right of the modifier on each detail line.

24E. **Diagnosis Code:** Required. Enter the ICD-9-CM diagnosis code that evidences the need for the use of medical nutritionals. A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. **$ Charges:** Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days or Units:** Required. Enter appropriate number of units.

24K. **Reserved for Local Use:** Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.:** Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment:** ***Required.*** Check **yes**.

28. **Total Charge:** Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid:** Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due:** Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered:** Required. Enter Medicare Statement Date *and* any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #:** Required. Put the *Name*, *Address*, and *Telephone Number* on all claim forms.

GRP#: **Required.** Enter the 7-digit provider number assigned by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

MEDICARE PART B CROSSOVER
(DO NOT FORGET TO ATTACH MEDICARE'S EOMB)

HEALTH INSURANCE CLAIM FORM

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PT 032732 SMITH A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, PAT

3. PATIENT'S BIRTH DATE MM DD YY: 03 27 32 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): PO BOX 17

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: XO

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 250.
2. .
3. .
4. .

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	10	01	03	10	30	03	12		B4034		250	1000	1				10.00
2	10	01	03	10	30	03	12		E0776	NU	250	10000	1				100.00
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. $ TOTAL CHARGE: 11000

29. $ AMOUNT PAID: 2000

30. $ BALANCE DUE: 9000

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

11/01/03

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

UPTOWN MEDICAL SUPPLY
13 ROSE STREET
UPTOWN, WA 98000 (206) 555-1111

PIN# 9045681 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

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Product Classification

Based on Centers for Medicare/Medicaid Services (CMS) guidelines, all enteral nutrition formulas are classified under one of six categories based on the composition and source of the ingredients in each product.

Category 1a (B4150)

Enteral formula consisting of semi-synthetic intact protein/protein isolates. Considered appropriate for the majority of clients requiring enteral nutrition:

Boost (with or without fiber)	Boost HP	Carnation Alsoy
Carnation Follow-up	Carnation Good Start	Enfacare
Enfamil	Ensure (with or without fiber)	Ensure High Protein
Fibersource	Glytrol	Isocal
Isomil	Isosource	Isosource HN
Jevity	Kindercal	Neosure
Nubasics (with or without fiber)	Nubasics VHP	Nutramigen
Nutren 1.0 (with or without fiber)	Nutren Junior	Osmolite
Pediasure	Portagen	Probalance
Promote (with or without fiber)	Resource	Resource Diabetic
Resource Just for Kids	Similac	Ultracal

Category 1b (B4151)

Blenderized enteral formula consisting of natural intact protein/protein isolates. Considered appropriate only for clients with a documented allergy or intolerance to semi-synthetic formulas:

Compleat
KetoCal
ProSobee

Category 2 (B4152)

Calorically dense intact protein/protein isolates. Considered appropriate only when determined medically necessary by a physician or nutritionist due to malabsorption conditions:

Boost Plus	Comply	Deliver 2.0
Ensure Plus	Ensure Plus HN	Isosource 1.5
Novasource 2.0	Novasource Pulmonary	Nubasics 2.0
Nubasics Plus	Nutren 1.5 & 2.0	Resource Plus
Respalor	TwoCal HN	VHC 2.25

Specialized Metabolic Nutrients

Category 3 (B4153)

Hydrolized protein/amino acids:

Alimentum	Criticare HN	Crucial
Cyclinex	Elecare	FAA (Free Amino Acid Diet)
GA 1 & 2	Glutarex 1 & 2	Glutasorb
Hominex 1 & 2	Impact Glutamine	Isotein HN
Ketonex 1 & 2	L-Emental	Neocate
Optimental	Peptamen 1.5	Peptamen with Prebio 1
Peptinex DT	Phenex 1 & 2	Propimex 1 & 2
Reabilan	Subdue	Tyrex 2
Valex 1 & 2	Vital HN	Vivonex Pediatric

Category 4 (B4154)

Defined formula for special metabolic need:

Advera	AlitraQ	Amino-Aid
Calcilco XD	Choice DM	Diabetisource
Glucerna	HCY 1 & 2	Hepatic-Aid
Immun-Aid	Impact (with or without fiber)	Impact 1.5
Impact Recover	Isosource VHN	Lipisorb
L-Emental Hepatic	Lofenalac	LYS 1 & 2
Magnacal Renal	Modulen IBD	MSUD
Nepro	Novasource Renal	Nutrihep
Nutrirenal	Nutrivent	OS 1 & 2
Peptamen	Peptamen Junior	Peptamen VHP
Perative	Phenyl-Free	Pregestimil
Product 3200AB	Product 3232	Pro-Peptide
Pulmocare	Re/Neph	RenalCal
Replete (with or without fiber)	Resource Benecalorie	Resource Diabetishield
SandoSource Peptide	Similac PM 60/40	Suplena
TraumaCal	Tyros 2	UCD 1 & 2
Vivonex Plus	Vivonex TEN	

Category 5 (B4155)

Modular components:

Additions	Casec	Duocal
Immunocal	MCT Oil	Microlipids
PFD 2	PhenylAde	PhenylAde MTE
Polycose Liquid & Powder	Pro-Cel	Product 80056
Promod	ProPhree	ProSure
ProViMin	RCF	Resource Arginaid
Resource Beneprotein	Resource Glutasolve	Upcal D

Category 6 (B4156)

Standardized nutrients:

Tolerex

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